

STATE OF MONTANA
Department of Public Health and Human Services
Human & Community Services Division



2007-2008
MERIT PAY
REQUEST TO CHANGE PLAN OF STUDY

NAME _____ PS NUMBER _____

DATE OF BIRTH _____ SSN _____

MAILING ADDRESS _____ CITY _____ ZIP _____

WORK PHONE _____ HOME PHONE _____

☐ *Check here if this is a new address*

Original Plan of Study training/course to be changed:	Number of Hours
Requested Change/Substitution course:	Number of Hours

Please use another sheet of paper if more space is needed.

I certify all information given is true and correct.

Applicant Signature: _____ **Date:** _____

Merit Pay participants must be actively working a minimum of 15 hours in a licensed/registered child care facility when payment is requested. Merit Pay participants must attach verification of training completed and a copy of their MT Early Care & Education Practitioner Registry before payment will be released. Non-college credit training can be verified and a copy printed at www.montana.edu/ecp/personnel using your PS number.

FOR ECSB OFFICE USE ONLY **APPROVED BY:** _____

DATE: _____